Pational Medicare
TRAINING PROGRAM
CENTERS FOR MEDICARE & MEDICARD SERVICES

Medicare
Advantage (MA)
Plans
Module 11



# ...helping people with Medicare make informed health care decisions



## Centers for Medicare & Medicaid Services National Train-the-Trainer Workshop Instructor Information Sheet Module 11: Medicare Advantage (MA) Plans

### **Module Description**

Medicare Advantage Plans, also known as Part C, provide Medicare-covered benefits to members, and sometimes offer extra benefits that Medicare doesn't cover, such as vision or dental services. This module provides a comprehensive overview of Medicare Advantage Plans, including who can join, when to join, how the plans work, and what you pay. This module also has a detailed lesson on Marketing Guidelines – the ways health plans may, and may not, market their plans.

These up-to-date materials are ready-to-use. They are designed for people who are familiar with the Medicare program, and would like to have prepared information for their presentations. Where applicable, updates from recent legislation are included.

The following sections are included in this module:

Slides	Topics	Slides	Topics
2	Session Objectives	17-25	Types of MA Plans
4-5	What is a Medicare Advantage (MA) Plan?	26-30	Other Medicare Plans
6-11	Eligibility/Enrollment Requirements	31-39	Rights, Protections, and Appeals
12-16	How MA Plans Work	40-59	Medicare Marketing Guidelines

### **Objectives**

- Define Medicare Advantage (MA) Plans
- Explain eligibility requirements and enrollment
- Define how MA Plans work

- Identify other Medicare Plans
- Recognize rights and protections including appeals
- Understand Medicare marketing guidelines

### **Target Audience**

This module is designed for presentation to trainers and other information givers. It is suitable for presentation to groups of beneficiaries.

### **Handouts**

Slides 10 and 35 are provided as full page handouts in the Appendix of this workbook. You may want to refer to these during your training if you provide copies of the workbooks to attendees. Or, you may wish to make copies of the handouts and distribute them as learning aids.

### **Time Considerations**

The module consists of 60 PowerPoint slides with corresponding speaker's notes. It can be presented in 1 hour. Allow approximately 30 more minutes for discussion, questions and answers.

### References

- To learn about the Medicare Advantage plans in your area, and the services they cover, visit www.medicare.gov
- For information on CMS demonstrations and pilot projects please visit www.cms.hhs.gov/DemoProjectsEvalRpts/
- For detailed information on the Medicare Part C Appeals Process, please visit www.Medicare.gov and select CMS Pub. #11312, Medicare Advantage Plans and Medicare Cost Plans: How to File a Complaint (Grievance or Appeal) CMS Pub. # 11312
- To review the Notice of Discharge and Medicare Appeal Rights visit www.cms.gov/Transmittals/Downloads/R4QIO.pdf



Module 11 *Medicare Advantage Plans & Other Medicare Plans* explains Medicare health care options other than Original Medicare.

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). The information in this module was correct as of April 2011.



To check for updates on health care reform, visit www.healthcare.gov/.



To check for an updated version of this training module, visit www.cms.gov/nationalmedicaretrainingprogram/tl/list.asp on the web.

This set of National Medicare Training Program materials is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

### **Session Objectives**

### This session will help you to

- Define Medicare Advantage (MA) Plans
- Explain eligibility requirements/enrollment
- Define how MA Plans work
- Identify types of MA Plans
- Identify other Medicare Plans
- Recognize rights/protections/appeals
- Understand Medicare marketing guidelines

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### This session will help you to

- Define Medicare Advantage (MA) Plans
- Explain eligibility requirements and enrollment
- Define how MA Plans work
- Identify types of MA Plans
- Identify other Medicare Plans
- Recognize rights and protections including appeals
- Understand Medicare marketing guidelines

### Lessons

- 1. What is a Medicare Advantage Plan?
- 2. Eligibility/Enrollment Requirements
- 3. How MA Plans work
- 4. Types of MA Plans
- 5. Other Medicare Plans
- 6. Rights Protections and Appeals
- 7. Medicare Marketing Guidelines

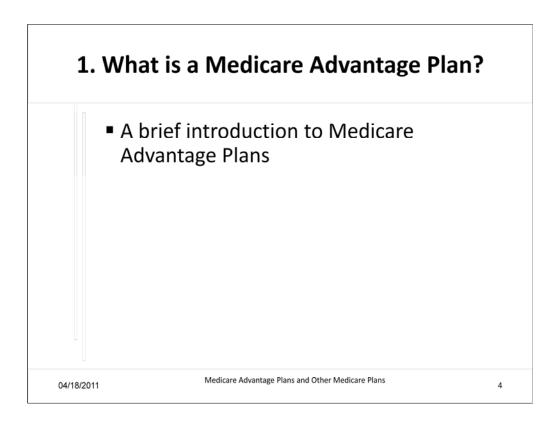
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### This module includes lessons on

- 1. What is a Medicare Plan?
- 2. Eligibility/Enrollment Requirements
- 3. How MA Plans work
- 4. Types of MA Plans
- 5. Other Medicare Plans
- 6. Rights Protections and Appeals
- 7. Medicare Marketing Guidelines



This brief lesson gives you the basic information on what a Medicare Advantage Plan is.

### What is a Medicare Advantage Plan?

- Health plan options
  - Approved by Medicare
  - Run by private companies
- Part of the Medicare program
- Sometimes called "Part C"
- Available across the country
- Provide Medicare-covered benefits
  - May cover extra benefits

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Medicare Advantage Plans and Other Medicare Plans

- MA Plans are health plan options that are approved by Medicare and are run by private companies.
- They are part of the Medicare program and are sometimes called "Part C."
- Medicare Advantage Plans are offered in many areas of the country by private companies that sign a contract with Medicare. Medicare pays a set amount of money to these private health plans for their members' health care.
- Medicare Advantage Plans provide Medicare-covered benefits to members through the plan, and may offer extra benefits that Medicare doesn't cover, such as vision or dental services. The plan may have special rules that its members need to follow.

### 2. Eligibility/Enrollment Requirements

- Who can join
- When you can join or switch
  - Initial Enrollment Period
  - Annual Enrollment Period
  - Special Enrollment Period

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### Eligibility/Enrollment explains

- Who can join
- When you can you join or switch
  - Initial Enrollment Period
  - Annual Enrollment Period
  - Special Enrollment Period

### Who Can Join?

- Eligibility requirements
  - Live in plan service area
  - Entitled to Medicare Part A (Hospital Insurance)
  - Enrolled in Medicare Part B (Medical Insurance)
  - No End-Stage Renal Disease (ESRD) at enrollment
    - Some exceptions
- To join a person must also
  - Provide necessary information to the plan
  - Follow the plan rules
  - Belong to one plan at a time

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- Medicare Advantage Plans are available to most people with Medicare. To be eligible to join
  a Medicare Advantage Plan, a person must
  - Live in the plan's geographic service area or continuation area
  - Be entitled to Medicare Part A (Hospital) and enrolled in Medicare Part B (Medical Insurance)
- People with End-Stage Renal Disease (ESRD) usually can't join an MA Plan or other Medicare plan. However, there are some exceptions. For example, an individual who develops ESRD while enrolled in an MA plan may continue to be enrolled in the MA plan, and some Medicare Advantage Special Needs Plans accept people with ESRD. A person who receives a kidney transplant and no longer requires a regular course of dialysis treatment is not considered to have ESRD for purposes of MA eligibility.
- To join an MA plan, a person must also
  - Agree to provide the necessary information to the plan,
  - Agree to follow the plan's rules, and
  - Belong to only one Medicare Advantage plan at a time.



To find out what Medicare Advantage Plans are available in a certain area, visit <a href="www.medicare.gov">www.medicare.gov</a> and under the Resource Locator choose the link "Drugs and Health Plans," or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.



More information on the enrollment exceptions for people with ESRD can be found in Section 20.2 of the Medicare Advantage enrollment and disenrollment guidance available at:

www.cms.gov/MedicareMangCareEligEnrol/

Initial Enrollment Period	<ul> <li>7 month period begins 3 months before the month you turn 65         <ul> <li>Includes the month you turn 6</li> <li>Ends 3 months after the mont you turn 65</li> </ul> </li> </ul>	
Annual Enrollment Period "Open Enrollment"	■ October 15 – December 7 ■ Coverage begins January 1	

- You can join a Medicare Advantage Plan when you first become eligible for Medicare, i.e.,
  - During your Initial Enrollment Period, which begins 3 months immediately before your first entitlement to both Medicare Part A and Part B, or
  - At any time a plan is allowing new members to join, which may be during the Annual Enrollment Period, and in certain special situations that provide a Special Enrollment Period.
- You can only join one Medicare Advantage Plan at a time, and enrollment in a plan is generally for a calendar year.
- You can switch to another Medicare Advantage Plan or to Original Medicare during the Annual Enrollment Period, also known as "Open Enrollment." This period runs from October 15 - December 7 each year, with coverage starting the following January 1.

**NOTE:** This chart is provided as a handout in the corresponding workbook (see Appendix A).



For more information about when you can join or switch MA Plans, see Section 3204 of the Affordable Care Act.

When you can Join or Switch MA Plans*			
Special Enrollment Period	<ul> <li>Move from plan service area</li> <li>And cannot stay in the pla</li> <li>Plan leaves Medicare program</li> <li>Other special situations</li> </ul>		
*Plan must be allowing new members to join			
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Special Enrollment Period: You may be able to join or switch MA plans under special circumstances that grant a Special Enrollment Period. For example, if a person moves out of the plan's service area, or if the plan decides to leave the Medicare program or reduce its service area at the end of the year, there are special rules that allow for enrollment in a different Medicare Advantage Plan, or Original Medicare and a Medigap policy.

**NOTE:** This chart is provided as a handout in the corresponding workbook (see Appendix A).



For more information about when you can join or switch MA Plans, see Section 3204 of the Affordable Care Act.

### When you can Join or Switch MA Plans\* New in 2011 ■ Between January 1-February 14 New in ■ Can leave MA plan Annual 2011 Disenrollment Switch to Original Medicare Period Coverage begins first day of month after switch ■ May join Part D Plan -Drug coverage begins first day of month after plan gets enrollment May not join another MA plan during this period \*Plan must be allowing new members to join

- New: If you belong to an MA plan, you can switch to Original Medicare from January 1 February 14. If you go back to Original Medicare during this time, plan coverage will take effect on the first day of the calendar month following the date on which the election or change was made.
- To disenroll from an MA plan and return to Original Medicare during this period, you can
  - Make a request directly to the MA organization
  - Call 1-800-MEDICARE
    - Enroll in a Medicare Prescription Drug Plan (PDP) also known as a Part D Plan
- If you make this change you may also join a PDP to add drug coverage. Coverage begins the first of the month after the plan gets the enrollment form.

**NOTE:** This chart is provided as a handout in the corresponding workbook (see Appendix A).

### **Special Enrollment Period Trial Rights**

- People who join MA Plan for first time
  - When first eligible at 65 or
  - Leave Original Medicare and drop Medigap
- Can disenroll during first 12 months
  - Enroll in Original Medicare
  - Have guaranteed issue for Medigap

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- There are special trial rights for a Special Enrollment Period available for people who have joined a Medicare Advantage plan for the first time. They can drop their MA plan and enroll in Original Medicare anytime within the first 12 months of their Medicare Advantage plan coverage. People are eligible for this trial right if they either
  - Joined an MA plan when first eligible for Medicare at age 65, or
  - Were in Original Medicare, enrolled in an MA plan for the first time, and dropped a Medigap policy.
- The trial right allows them to disenroll from the MA plan during the first 12 months to join Original Medicare. They also have a guaranteed issue opportunity to purchase a Medigap (Medicare supplement insurance) policy.

### 3. How MA Plans Work

- Which services you may receive
- Doctor and hospital networks
- MA Plans vs. Original Medicare
- MA Plan Costs
- What is new in 2011

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### **How MA Plans Work explains**

- Which services you may receive
- Doctor and hospital networks
- MA Plans vs. Original Medicare
- MA Plan Costs
- What is new in 2011

### **How MA Plans Work**

- Receive services through the plan
  - All Part A and Part B covered services
  - Some plans may provide additional benefits
- Most plans include prescription drug coverage
- You may have to visit network doctors/hospitals
- May be different than Original Medicare
  - Benefits
  - Cost-sharing

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- In most Medicare Advantage Plans, you receive all Part A and B Medicare-covered services through that plan. Some MA plans provide additional benefits.
- Many plans also include Medicare prescription drug coverage. This is Medicare Part D coverage.
- Medicare pays a set amount of money for your care every month to these private health plans whether you use services or not.
- In some plans, like HMOs, you may only be able to see certain doctors or go to certain hospitals.
  - Benefits and cost-sharing in a Medicare Advantage Plan may be different than in Original Medicare.

### **How MA Plans Work**

- You are still in Medicare program
- You still have Medicare rights and protections
- If the plan leaves Medicare
  - You can join another MA Plan
  - You can return to Original Medicare

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- It's important to note that people who join a Medicare Advantage Plan or other Medicare plan
  - Are still in the Medicare program
  - Still have Medicare rights and protections, and
  - If the plan decides to stop participating in Medicare, you will have to join another Medicare health plan or return to Original Medicare.

### **MA Costs**

- Must still pay Part B premium
  - Some plans may pay all or part for you
  - State assistance for some
- May pay additional monthly premium
- You pay deductibles, coinsurance and copayments
  - Different from Original Medicare
  - Varies from plan to plan
  - Costs may be higher if out-of-network

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- If you join a Medicare Advantage Plan you must continue to pay the monthly Medicare Part B premium. The Part B premium in 2011 is \$110.50 (\$96.40 for most people who meet certain income levels).
  - Some plans may pay all or part for you
  - Some people may be eligible for state assistance
- You may pay additional monthly premium to plan
- You pay deductibles, coinsurance and copayments
  - Different from Original Medicare
  - Varies from plan to plan
  - Costs may be higher if you go out of network

### **MA - New for 2011**



- Plans can't charge more than Original Medicare
  - Chemotherapy
  - Dialysis
  - Skilled nursing facility care
  - Certain other services
- Plans must limit out-of-pocket costs
- Participants in approved clinical research study
  - Costs may be lower
  - Plan may cover some costs

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Let's discuss some of the things that are new in 2011:

- MA Plans can't charge more than Original Medicare (Affordable Care Act Section 3202)
  - For certain services, e.g., chemotherapy, dialysis, and skilled nursing facility care
- MA Plans must limit your out-of-pocket costs
  - For Part A and Part B covered services (Affordable Care Act Section 3202)
- If you are accepted as a participant in an approved clinical research study
  - Your costs may be lower
  - Some of your costs may be covered by your plan



For more on Part A and Part B covered services, see Affordable Care Act Sections 2101 and 3202.

### 4. Types of MA Plans

- Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)
- Private Fee-for-Service (PFFS)
- Special Needs Plan (SNP)
- HMO Point-of-Service Plan (HMOPOS)
- Medicare Medical Savings Account (MSA)

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Types of MA Plans explains the six main types of Medicare Advantage Plans. They are

- Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)
- Private Fee-for-Service (PFFS)
- Special Needs Plan (SNP)
- HMO Point-of-Service Plan (HMOPOS)
- Medicare Medical Savings Account (MSA)

Medicare HMO Plan		
Can you get your health care from any doctor or hospital?	No. You generally must get your care and services from network providers.	
Are prescription drugs covered?	Yes, in most cases.	
Do you need to choose a primary care doctor?	Yes, in most cases.	
Do you need a referral to see a specialist?	Yes, in most cases.	
What else do you need to know about this type of plan?	What to do about:  Your doctor leaving the plan Getting health care outside the plan network Following plan rules	

### ■ In a HMO Plan

- You generally must get your care and services from doctors or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis). In some plans, you may be able to go out-of-network for certain services, usually for a higher cost. This is called a HMO with a POS option.
- In most cases, prescription drugs are covered. Ask the plan. If you want drug coverage,
   you must join a HMO Plan that offers prescription drug coverage.
- In most cases, you need to choose a primary care doctor.
- In most cases, you will have to get a referral to see a specialist. Certain services like yearly screening mammograms don't require a referral.
- If your doctor leaves the plan, your plan will notify you and you can choose another doctor in the plan.
- If you get care outside the plan network, you may have to pay the full cost.
- It's important that you follow the plan rules, like getting prior approval for a certain service when needed.
- MA plans can vary. Read individual plan materials carefully to make sure you understand the plan rules. You may want to contact the plan to find out if the service you need is covered and how much it costs.



Visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to find plans in your area. TTY users should-call 1 877 486 2048.



**NOTE:** Information in this chart, and those on the following slides are from the 2011 *Medicare & You* handbook, CMS Pub. # 10050. It can be viewed at <a href="http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf">http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf</a>.

PPO Plan		
Can you get your health care from any doctor or hospital?	Yes. PPOs have networks, but you can use out-of-network providers, usually for a higher cost.	
Are prescription drugs covered?	Yes, in most cases.	
Do you need to choose a primary care doctor?	No	
Do you need a referral to see a specialist?	No	
What else do you need to know about this type of plan?	■There are two types of PPOs— Regional PPOs and local PPOs.	
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### ■ In a Medicare PPO Plan

- You have PPO network doctors and hospitals, but you can also use out-of-network providers for covered services, usually for a higher cost.
- In most cases, prescription drugs are covered. Ask the plan. If you want drug coverage, you must join a PPO Plan that offers prescription drug coverage.
- You do not need to choose a primary care doctor.
- You do not have to get a referral to see a specialist.
- There are two types—Regional PPOs and Local PPOs.
  - A regional PPO serves one of 26 regions set by Medicare.
    - o Appeals to beneficiaries who seek treatment in a state other than their state of residence.
    - Appeals to beneficiaries who spend a large portion of the year in a state other than their state of residence each year (e.g. Snowbirds)
  - Local PPOs serve the counties the PPO Plan chooses to include in its service area. Local PPOs have mandatory limits on out-of-pocket costs that are set by Medicare
- MA Plans can vary. Read individual plan materials carefully to make sure you understand the plan rules. You may want to contact the plan to find out if the service you need is covered and how much it costs.





Visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to find plans in your area. TTY users should call 1-877-486-2048.

Medicare PFFS Plan		
Can you get your health care from any doctor or hospital?	You can go to any Medicare-approved provider that accepts the plan payment terms and agrees to treat you. Not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members.	
Are prescription drugs covered?	Sometimes. If your PFFS plan doesn't offer drug coverage, you can join a Medicare prescription drug plan.	
Do you need to choose a primary care doctor?	No	
Do you need a referral to see a specialist?	No	

- In a Medicare Private-Fee-for-Service Plan
  - You can go to any Medicare-approved doctor or hospital that accepts the plan's payment terms and agrees to treat you. Not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members.
  - Prescription drugs are sometimes covered. If your PFFS Plan doesn't offer drug coverage, you can join a Medicare prescription drug plan to get coverage.
  - You don't need to choose a primary care doctor.
  - You don't have to get a referral to see a specialist.

### **Medicare PFFS Plan** What else do you ■ Not the same as Original Medicare or Medigap need to know Plan decides what you pay for services about this type of Some contract with a network of providers who plan? agree to always treat you ■ In a PFFS Plan with a network, you may pay more if you choose an out-of-network provider. Out-of-network providers may decide not to treat ■ Make sure your providers agree to treat you and accept the plan payment terms In an emergency, providers must treat you. 04/18/2011 Medicare Advantage Plans and Other Medicare Plans 21

- Other things you need to know about Medicare PFFS Plans include
  - PFFS Plans aren't the same as Original Medicare or Medigap.
  - The plan decides how much you pay for services.
  - Some PFFS Plans contract with a network of providers who agree to always treat you
    even if you've never seen them before.
  - If you join a PFFS Plan that has a network, you may pay more if you choose an out-of-network doctor, hospital, or other provider.
  - Out-of-network doctors, hospitals, and other providers may decide not to treat you
    even if you've seen them before.
  - For each service, make sure your doctors, hospitals, and other providers agree to treat you under the plan, and accept the plan's payment terms.
  - In an emergency, doctors, hospitals, and other providers must treat you.
- MA Plans can vary. Read individual plan materials carefully to make sure you understand the plan's rules. You may want to contact the plan to find out if the service you need is covered and how much it costs.





Visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to find plans in your area. TTY users should call 1-877-486-2048.

### **PFFS Access Requirements in 2011**



- Employer PFFS plans must meet access requirements
- Plans may meet access requirements through a contracted network of providers
- Where two or more network-based MA plan options exist
  - Non-employer PFFS plans must meet access requirements through contracts with providers

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- The Medicare Improvements for Patients and Providers Act (MIPPA) required that beginning in 2011 all employer Private-Fee-for-Service plans must have met Medicare access requirements through contracts with providers. Access requirements are in place to make sure that beneficiaries have access to a sufficient number of providers in their area who are willing to treat them.
- Employer and non-employer PFFS plans may meet access requirements through a contracted network of providers that meets CMS requirements or by paying no less than the Original Medicare payment rate and having providers deemed to be contracted, as provided under providers accepting the plans' terms and conditions of payment, on a patient-by-patient and visit-by-visit basis—this process is also known as deeming.
- Additionally, all non-employer PFFS plans must meet Medicare access requirements through contracts with providers if two or more network-based MA plan options exist.

Medicare Special Needs Plan				
Can you get your health care from any doctor or hospital?	You generally must get your care and services from doctors or hospitals in the plan network.			
Are prescription drugs covered?	Yes.			
Do you need to choose a primary care doctor?	Generally, yes.			
Do you need a referral to see a specialist?	In most cases, yes.			
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- Medicare Special Needs Plans are Medicare Advantage plans designed to provide focused care management, special expertise of the plan's providers, and benefits tailored to enrollee conditions.
- You generally must get your care and services from doctors or hospitals in the plan network except for emergency care, out-of-area urgent care, or out-of-area dialysis.
- All SNPs must provide Medicare Part D coverage.
- You generally do need to choose a primary care doctor.
- In most cases, you do need a referral to see a specialist. Certain services like yearly screening mammograms don't require a referral.

### **Medicare SNPs**

# What do you need to know about this type of plan?

- A plan must limit plan membership to people in one of the following groups:
  - Those living in certain institutions
  - Those eligible for both Medicare and Medicaid
  - Those with one or more specific chronic or disabling conditions
- Plan may further limit membership
- Plan should coordinate your needed services and providers
- Plan should make sure plan providers you use accept Medicaid if you have Medicare and Medicaid
- Plan should make sure plan providers serve people where you live if you live in an institution

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- There are things you need to know about a Special Needs Plan:
  - A plan must limit plan membership to people in one of the following groups:
    - 1) People who live in certain institutions (like a nursing home) or who require nursing care at home, or
    - 2) People who are eligible for both Medicare and Medicaid, or
    - 3) People who have one or more specific chronic or disabling conditions like diabetes, congestive heart failure, a mental health condition, or HIV/AIDS.
  - Plans may further limit membership within these groups.
  - Plans should coordinate the services and providers you need to help you stay healthy and follow your doctor's orders.
  - If you have Medicare and Medicaid, your plan should make sure that all of the plan doctors or other health care providers you use accept Medicaid.
    - If you live in an institution, make sure that plan doctors or other health care providers serve people where you live.
  - MA Plans can vary. Read individual plan materials carefully to make sure you
    understand the plan rules. You may want to contact the plan to find out if the service
    you need is covered and how much it costs.





Visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to find plans in your area. TTY users should call 1-877-486-2048.

### **Less Common MA Plans**

- HMO Point of Service (HMOPOS) Plan
  - May allow out-of-network services
- Medical Savings Account (MSA) Plans
  - Combine high deductible plan with bank account
  - Medicare deposits money into account
  - Use money to pay for services

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- Other, less common types of MA Plans include
  - HMO Point of Service (HMOPOS) Plans—A plan that may allow you to get some services out-of-network for a higher cost.
  - Medical Savings Account (MSA) Plans—A plan that combines a high deductible health plan with a bank account. Medicare deposits money into the account, and you use the money to pay for your health care services.





For more information about MSAs, visit <a href="https://www.medicare.gov/Publications/Pubs/pdf/11206.pdf">www.medicare.gov/Publications/Pubs/pdf/11206.pdf</a> to view the booklet, "Your Guide to Medicare Medical Savings Account Plans." You can also call 1-800-MEDICARE (1-800-633-4227) to have a copy mailed to you. TTY users should call 1-877-486-2048.

# 5. Other Types of MA Plans Medicare Cost Plans Demonstrations and Pilot Programs PACE (Programs of All-inclusive Care for the Elderly)

Other Types of MA Plans explains three other MA Plan types:

- Medicare Cost Plans
- Demonstrations and Pilot Programs
- PACE (Programs of All-inclusive Care for the Elderly)

### **Other Medicare Plans**

- Not MA, still part of Medicare
- Some provide Part A and/or Part B coverage
- Some provide Part D coverage
- They include
  - Medicare Cost Plans
  - Demonstrations/Pilot Programs
  - Programs of All-inclusive Care for the Elderly (PACE)

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- Some types of Medicare health plans that provide health care coverage aren't MA Plans but are still part of Medicare. Some of these plans provide Part A (Hospital Insurance) and/or Part B (Medical Insurance) coverage, and some also provide Part D (Medicare prescription drug) coverage. These plans have some of the same rules as MA Plans. Some of these rules are explained briefly on the next few slides. However, each type of plan has special rules and exceptions, so you should contact any plans you're interested in to get more details.
- These plans include
  - Medicare Cost Plans—similar to a HMO, but services received outside the plan are covered under Original Medicare
  - Demonstrations and Pilot Programs—special projects that test possible future improvements in Medicare coverage, costs, and quality of care
  - PACE (Programs of All-inclusive Care for the Elderly)—combine medical, social, and long-term care services for frail elderly people

**NOTE:** The next several slides provide a brief overview of each of the types of other Medicare plans. You are encouraged to insert slides and information specific to the plans available in **your** area.

### **Cost Plans**

- Available in limited areas
- Must have Part B to join
- Can see a non-network provider
  - Services covered under Original Medicare
- Join anytime new members being accepted
- Leave any time
  - Return to Original Medicare
- Get Medicare prescription drug coverage
  - From the plan (if offered)
  - Buy Medicare prescription drug plan

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- Medicare Cost Plans are a type of Medicare health plan available only in certain areas of the country.
- Medicare Cost Plans work like this:
  - You can join even if you only have Part B.
  - If you go to a non-network provider, the services are covered under Original Medicare. You would pay the Part B premium, and the Part A and Part B coinsurance and deductibles.
  - You can join a Medicare Cost Plan any time it is accepting new members.
  - You can leave a Medicare Cost Plan any time and return to Original Medicare.
  - You can either get your Medicare prescription drug coverage from the plan (if offered), or you can buy a Medicare prescription drug plan to add prescription drug coverage. You can only add or drop Medicare Prescription Drug coverage at certain times. For more information about Medicare Cost Plans, contact the plan you're interested in.
  - Your State Health Insurance Assistance Program (SHIP) can also give you more information.



You can also visit www.medicare.gov on the web.

### **Demonstrations and Pilot Programs**

- Special projects that test improvements
  - Medicare coverage
  - Payment
  - Quality of care
- Eligibility usually limited
  - Specific group of people
  - Specific area of country
- Examples
  - MA Plan for End-Stage Renal Disease patients
  - New Medicare preventive services

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- Medicare Demonstrations and Pilot Programs are special projects that test improvements in Medicare coverage, payment, and quality of care. They are usually for a specific group of people and/or are offered only in specific areas. Some follow MA Plan rules, but others don't. The results of demonstrations have helped shape many of the changes in Medicare over the years.
- Check with the demonstration or pilot program for more information about how it works.





To find more information, visit <a href="www.cms.gov/DemoProjectsEvalRpts/">www.cms.gov/DemoProjectsEvalRpts/</a> or <a href="www.medicare.gov">www.medicare.gov</a> on the web, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

**NOTE:** Instructor may add state specific content or provide an example.

### **Medicare PACE Plans**

- Programs of All-inclusive Care for the Elderly
- Combine services for frail elderly people
  - Medical, social, long-term care services
  - Include prescription drug coverage
- Alternative to nursing home care
- Only in states that offer under Medicaid
- Qualifications vary from state to state
  - Contact state Medical Assistance office for information

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- Programs of All-inclusive Care for the Elderly (PACE) combine medical, social, and long-term care services for frail elderly people who live in and get health care in the community. PACE programs provide all medically-necessary services, including prescription drugs. PACE might be a better choice for some people instead of getting care through a nursing home. PACE is a joint Medicare and Medicaid program that may be available in states that have chosen it as an optional Medicaid benefit, and the qualifications for PACE vary from state to state.
- Call your state Medical Assistance (Medicaid) office to find out about eligibility and if a PACE site is near you.



You can also visit <u>www.cms.gov/pace</u> on the web for PACE locations and telephone numbers.

**NOTE:** Instructor may highlight local plans.

### 6. Rights Protections and Appeals

- Guaranteed Rights and Protections
- Appeals Process
- Appeal Rights
- Required Notices

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### This lesson explains

- Guaranteed Rights and Protections
- Appeals Process
- Appeal Rights
- Required Notices

### **Guaranteed Rights**

- To get needed health care services
- To receive easy-to-understand information
- To have personal medical information kept private

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All people with Medicare have certain guaranteed rights and protections. They have them whether they are in Original Medicare, in an MA Plan or other Medicare plan, have a Medicare drug plan, or have a Medigap policy.

- These following rights are guaranteed:
  - To get the health care services they need
  - To receive easy-to-understand information
  - To have their personal medical information kept private

### **Rights in Medicare Health Plans**

- Choice of health care providers
- Access to health care providers (treatment plan)
- Know how your doctors are paid
- Fair, efficient, and timely appeals process
- Grievance process
- Coverage/payment information before service
- Privacy of personal health information

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- If you're in a Medicare health plan, in addition to the rights and protections previously described, you have the right to
  - Choose health care providers in the plan so you can get covered health care.
  - Get a treatment plan from your doctor if you have a complex or serious medical condition. A treatment plan lets you directly see a specialist within the plan as many times as you and your doctor think you need to. Women have the right to go directly to a women's health care specialist within the plan without a referral for routine and preventive health care services.
  - Know how your doctors are paid if you ask your plan. Medicare doesn't allow a plan to pay doctors in a way that interferes with you getting needed care.
  - A fair, efficient, and timely appeals process to resolve payment and coverage disputes with your plan. You have the right to ask your plan to provide or pay for a service you think should be covered, provided, or continued.
  - File a grievance about other concerns or problems with your plan, e.g., if you believe your plan hours of operation should be different, or there aren't enough specialists in the plan to meet your needs. Check your plan membership materials or call your plan to find out how to file a grievance.
  - Get a coverage decision or coverage information from your plan before getting services to find out if it will be covered or to get information about your coverage rules. You can also call your plan if you have questions about home health care rights and protections. Your plan must tell you if you ask.
  - Privacy of personal health information. For more information about your rights to privacy, look in your plan materials, or call your plan.
  - For more information, read your plan's membership materials or call your plan.

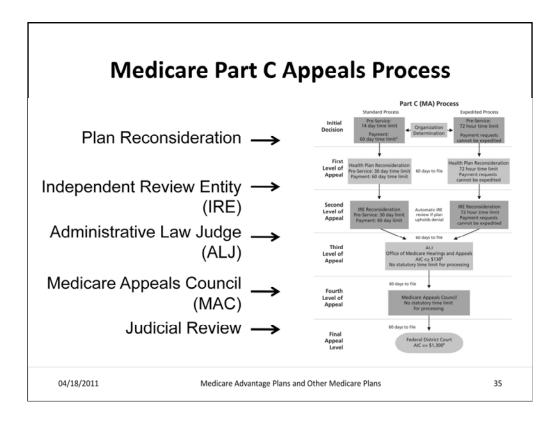
### **Appeals in Medicare Advantage**

- Plan must say in writing how to appeal
  - Will not pay for a service
  - Does not allow a service
  - Stops or reduces course of treatment
- Can ask for fast (expedited) decision
  - Plan must decide within 72 hours
- See plan membership materials
  - Instructions on how to file an appeal or grievance

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Medicare Advantage Plans and Other Medicare Plans

- The plan must tell its members in writing how to appeal. People in an MA Plan or other Medicare plan can appeal if their plan will not pay for, does not allow, stops or reduces a course of treatment that they think should be covered or provided. If they think their health could be seriously harmed by waiting for a decision about a service, they should ask the plan for an expedited appeal decision.
- If a request for an expedited decision is requested or supported by a doctor, the plan must make a decision within 72 hours. The member or the plan may extend the time-frame up to 14 days to get more medical information. After an appeal is filed, the plan will review its decision. Then, if the plan does not decide in the member's favor, an independent organization that works for Medicare—not for the plan—reviews the decision. See the plan membership materials or contact the plan for details about its members' Medicare appeal rights.



- This chart shows the appeal process for Medicare health plan enrollees. The time frames differ depending on whether you are requesting a standard appeal, or if you qualify for an expedited appeal.
- If you ask your plan to provide or pay for an item or service and your request is denied, you can appeal the plan's initial decision (the "organization determination"). You will get a notice explaining why your plan denied your request and instructions on how to appeal your plan's decision.
- There are five levels of appeal. If you disagree with the decision made at any level of the process, you can go to the next level if you meet the requirements for doing so.
- After each level, you will get instructions on how to proceed to the next level of appeal. The five levels are as follows:
- Reconsideration by the Medicare health plan
- Reconsideration by the Independent Review Entity
- Hearing with the Administrative Law Judge
- Review by the Medicare Appeals Council (MAC)
- Review by a federal district court



For more detailed information, view the publication *Medicare Advantage Plans and Medicare Cost Plans: How to File a Complaint (Grievance or Appeal)* at www.medicare.gov/Publications/Pubs/pdf/11312.pdf.

**NOTE:** This chart is available as a handout in the corresponding workbook (see Appendix B).

## Medicare Health Plan Fast Appeals Process

- Notice of Medicare Non-Coverage
  - Provider must deliver at least 2 days before care will end
- If you think services are ending too soon
  - Contact your Quality Improvement Organization (QIO)
- QIO must notify you of its decision
  - COB the day after it receives all necessary information

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- With the Medicare Health Plan Fast Appeals Process
  - You have the right to ask your plan to provide or pay for a Medicare-covered service you think should be continued in a skilled nursing facility, from a home health agency, or in a comprehensive outpatient rehabilitation facility.
  - Your provider must deliver a Notice of Medicare Non-Coverage at least 2 days before Medicare-covered skilled nursing facility (SNF,) comprehensive outpatient rehabilitation facility (CORF,) or home health aide (HHA) care will end.
- If you think services are ending too soon, contact your Quality Improvement Organization (QIO) no later than noon the day before Medicare-covered services end to request a fast appeal.
  - See your notice for how to contact your QIO and for other important information.
- The QIO must notify you of its decision by close of business of the day after it receives all necessary information.
  - The plan must give you a Detailed Explanation of Non-Coverage. This notice will explain why the coverage is being discontinued.
  - You have the right to ask for a reconsideration by the QIO if you are dissatisfied with the results of the fast appeal.

### **Inpatient Hospital Appeals**

- Provider/plan must provide NODMAR
  - At least the day before services end if
    - Enrollee disagrees with discharge decision
    - Provider/plan lowers the enrollee's care level
- Appeal to QIO by noon of first day after NODMAR
- Decision from QIO usually within 2 days
  - Enrollee remains in hospital
  - Incurs no financial liability until QIO gives decision

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- For inpatient hospital appeals, the provider or plan must provide a *Notice of Discharge and Medicare Appeal Rights (NODMAR)* at least the day before services end if the enrollee disagrees with the discharge decision, or if the provider or plan is lowering the level of the enrollee's care within the same facility.
- The person can then appeal by sending a request to the Quality Improvement Organization (QIO) by noon of the first day after receiving the NODMAR. The decision from the QIO is usually received within 2 days. The enrollee remains in the hospital pending the QIO's decision, and generally incurs no financial liability.
- However, you should be aware that you could be financially liable for inpatient hospital services provided after noon of the day after the QIO gives its decision. You may leave the hospital on or before that time and avoid any possible financial liability.



More information on the notice is available at www.cms.gov/Transmittals/Downloads/R4QIO.pdf

## Rights if You File an Appeal with Your Medicare Health Plan

- Right to plan files about you (your case file)
  - Call or write your plan
  - Plan may charge a fee

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- If you are in a Medicare health plan and you are filing an appeal, you have certain rights. You may want to call or write your plan and ask for a copy of your file. Look at your Evidence of Coverage, or the notice you received that explained why you could not get the services you requested, to get the phone number or address of your plan.
- The plan may charge you a fee for copying this information and sending it to you. Your plan should be able to give you an estimate of how much it will cost based on the number of pages contained in the file, plus normal mail delivery.

### **Required Notices**

- Plans must provide notices after every
  - Adverse determination
  - Adverse appeal
- Notice must include
  - Detailed explanation of services denied
  - Next appeal level
  - Specific instructions

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Medicare Advantage Plans and Other Medicare Plans

- Plan sponsors are required to provide notices after every adverse coverage determination, also referred to as initial decision or appeal.
- In addition, all appeal entities are required to send written notice when they make adverse decisions. These notices will explain the decision, including a detailed explanation of why the services were denied, information on the next appeal level, and specific instructions about how to file the appeal.

### 7. Medicare Marketing Guidelines

- Marketing Provisions
- Key Updates
- Promotional Activity Reminders
- Agent Information
- Marketing Surveillance

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### Medicare Marketing Guidelines explains

- Marketing Provisions
- Key Updates
- Promotional Activity Reminders
- Agent Information
- Marketing Surveillance

### **Marketing Provisions**

- Final Medicare Marketing Guidelines
  - Released June 4, 2010
- Policy clarifications and operational guidance
  - Effective for contract year 2011
- CMS marketing requirements apply
  - Medicare Advantage Plans
  - Prescription Drug Plans
  - Cost Plans

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- The final guidelines, released on June 4, 2010, include revisions to clarify policy and streamline operational guidance for health plans.
- CMS marketing requirements apply to Medicare Advantage Plans, Prescription Drug Plans and Cost Plans unless indicated otherwise in regulation or guidance.

### **Marketing Provisions**

- Certain beneficiary communication materials
  - Do not require review
  - Plan sponsors are required to use standardized model marketing materials under Parts C & D
    - When CMS provides standardized model materials

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- Ad Hoc beneficiary communications materials under Parts C and D
  - Ad hoc communications materials about claims processing activities is excluded from the definition of marketing materials.
  - While current enrollee communication materials are not subject to the review and approval process that applies to marketing materials, CMS retains the right to review and approve current enrollee communication materials.
  - Required use of standardized model marketing materials under Parts C and Part D
  - Require that Medicare Advantage Organizations and Prescription Drug Plan sponsors use standardized marketing material language and format, without modification, in every instance in which CMS provides standardized language and formatting.

### **New Marketing Updates**

- Non-health, non-plan related mailings
- Social networking website marketing
- Broker/agent compensation

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Medicare Advantage Plans and Other Medicare Plans

- Plan sponsors must include the plan name or logo on non-health related, non-plan related beneficiary mailings.
- Plan sponsors may use social networking sites, such as Facebook and Twitter, to market their products. CMS will monitor these sites carefully and as a result, may make future policy changes.
- CMS has established limits on compensation to make sure that brokers and agents are not incentivized to encourage beneficiaries to select plans that may not meet their needs and/or preferences.

### Disclosure of Plan Information for New and Renewing Members

- MA and PDPs must disclose plan information
  - At time of enrollment and at least annually
    - Required Annual Notice of Change/Evidence of Coverage
    - Comprehensive or Abridged Formulary
    - · Pharmacy Directory
    - Provider Directory
    - Member ID card at the time of enrollment/as needed

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Medicare Advantage Plans and Other Medicare Plans

- To ensure that beneficiaries receive comprehensive plan information regarding their healthcare options, CMS requires MA and PDP organizations to disclose certain plan information both at the time of enrollment and at least annually, 15 days prior to the Annual Election Period.
  - This requirement includes the annual dissemination of the standardized Annual Notice of Change and Evidence of Coverage that must be received by members no later than October 31 each year.
  - Comprehensive formulary or abridged formulary including information on how the beneficiary can obtain a complete formulary (Part D sponsors only)
  - Pharmacy directory (For all plan sponsors offering a Part D benefit)
  - Provider directory (All plan types except PDPs)
    - Membership identification card (required only at time of enrollment and as needed or required by plan sponsor post-enrollment)

### **Nominal Gifts**

- Organizations can offer gifts to potential enrollees
  - Must be of nominal value
    - Defined in marketing guidelines
    - Currently set at \$15, based on retail price
- Must be given whether beneficiary enrolls or not

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Organizations can offer gifts to potential enrollees as long as such gifts are of nominal value and are provided whether or not the individual enrolls in the plan. Nominal value currently is defined as an item worth \$15 or less, based on the retail purchase price of the item regardless of the actual cost. CMS will update the nominal value in guidance as necessary to account for inflation and other relevant factors.

### **Unsolicited Contacts**

- Extends existing door-to-door solicitation prohibition
  - Outbound marketing calls
  - Common areas
  - Calls/visits after attending sales event
  - Unless express permission given
  - Unsolicited emails

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Medicare Advantage Plans and Other Medicare Plans

- The prohibition on door-to-door solicitation extends to other instances of unsolicited contact that may occur outside of advertised sales or educational events. Prohibited activities include, but are not limited to, the following
  - Outbound marketing calls, unless the beneficiary requested the call. This includes contacting existing members to market other Medicare products, except as permitted below.
  - Calls to former members who have disenrolled, or to current members who are in the process of voluntarily disenrolling, to market plans or products, except as permitted below.
  - Calls to beneficiaries to confirm receipt of mailed information, except as permitted below.
  - Calls to beneficiaries to confirm acceptance of appointments made by third parties or independent agents.
  - Approaching beneficiaries in common areas (i.e. parking lots, hallways, lobbies, etc.)
  - Calls or visits to beneficiaries who attended a sales event, unless the beneficiary gave express permission at the event for a follow-up call or visit.
- Organizations may do the following
  - Conduct outbound calls to existing members to conduct normal business related to enrollment in the plan, including calls to members who have been involuntarily disenrolled to resolve eligibility issues.
  - Call former members after the disenrollment effective date to conduct disenrollment survey for quality improvement purposes. Disenrollment surveys may be done by phone or sent by mail, but neither calls nor mailings may include sales or marketing information.
  - Under limited circumstances and subject to advance approval from the appropriate CMS Regional Office, call LIS-eligible members when their plan is prospectively losing due to reassignment to encourage them to remain enrolled in their current plan.
  - Call beneficiaries who have expressly given permission for a plan or sales agent to contact them, for
    example by filling out a business reply card or asking a Customer Service Representative (CSR) to have an
    agent contact them.

### **Cross Selling**

- Prohibited during any MA or Part D sales activity/presentation
- Cannot market non-health related products
  - Annuities
  - Life insurance
  - Other products
- Allowed on inbound calls per request

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- Marketing health care related products (such as annuities and life insurance) to prospective enrollees during any MA or Part D sales activity or presentation is considered cross-selling and is a prohibited activity. Beneficiaries already face difficult decisions regarding Medicare coverage options and should be able to focus on Medicare options without confusion or implication that the health and the non-health products are a package. Plans may sell non-health related products on inbound calls when a beneficiary requests information on other non-health related products. Marketing to current plan members of non-MA plan covered health care products, and/or non-health care products, is subject to Health Insurance Portability and Accountability Act (HIPAA) rules.
- CMS is concerned about the marketing of non-health related products during hold-time messages and on interactive voice response (IVR) systems that plans may use to automate their inbound calling interface. We are considering providing guidance on prohibiting or limiting cross-selling during these types of messages, and are interested in receiving industry feedback during User Group calls.

### Scope of Appointments

- Must specify product type
  - Prior to marketing and/or in-home appointment
    - Medigap
    - MA
    - PDP
    - Other
- Additional products can only be discussed
  - On beneficiary request
  - At separate appointment

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Medicare Advantage Plans and Other Medicare Plans

- Medicare Marketing Guidelines require marketing representatives to clearly identify the types of products to be discussed before marketing to a potential enrollee. Marketing representatives who initially meet with a beneficiary to discuss specific lines of plan business (separate lines of business include Medigap, MA, and PDP) must inform the beneficiary of all products to be discussed prior to the in-home appointment so they have accurate information to make an informed choice about their Medicare benefits without pressure.
- Before a marketing appointment, the beneficiary must agree to the scope of the appointment. The agreement must be documented by the plan in writing or recorded by phone. Example: A beneficiary attends a sales presentation and schedules an appointment. The agent must get written documentation signed by the beneficiary agreeing to the products that will be discussed during the appointment.
- Appointments made over the phone must be documented by a recording. Organizations should
  use their existing systems to monitor and track calls where there is beneficiary interaction.
   Organizations that contact a beneficiary in response to a reply card may only discuss the products
  that were included in the advertisement.
- Additional products may not be discussed unless the beneficiary requests the information. In addition, any additional lines of plan business that are not identified prior to the in-home appointment will require a separate appointment.

### **Health Care Settings**

- Marketing allowed in common areas
  - Hospital or nursing home cafeterias
  - Community or recreational rooms
  - Conference rooms
- No marketing in health care setting
  - Waiting rooms
  - Exam rooms and hospital patient rooms
  - Dialysis centers and pharmacy counter areas

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- Organizations may not conduct marketing activities in health care settings except in common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms. If a pharmacy counter is located within a retail store, common areas would include the space outside of where patients wait for services or interact with pharmacy providers and obtain medications.
- Plans are prohibited from conducting sales presentations and distributing and accepting enrollment applications in areas where patients primarily intend to receive health care services. These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, dialysis centers, and pharmacy counter areas (where patients wait for services or interact with pharmacy providers and obtain medications). Only upon request by the beneficiary are plans permitted to schedule appointments with beneficiaries residing in long-term care facilities. Additionally, providers are permitted to make available and/or distribute plan marketing materials for all plans with which the provider participates and display posters or other materials announcing plan contractual relationships.

### **Educational Events**

- No marketing activities at educational events
  - Health information fairs
  - Conference expositions
  - State- or community-sponsored events
- Plans may distribute
  - Medicare and/or health educational materials
  - Agent/broker business cards
    - Containing no marketing information

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- Educational events may not include sales activities such as the distribution marketing materials or the distribution or collection of plan applications. CMS has clarified that the purpose of educational events is to provide objective information about the Medicare program and/or health improvement and wellness. As such, educational events should not be used to steer or attempt to steer a beneficiary toward a specific plan.
- Organizations that sponsor or participate in educational events must include a disclaimer on event advertising materials that the event is "educational only and information regarding the plan will not be available."
- Educational events may be sponsored by the plan(s) or by outside entities, and are events that are promoted to be educational in nature and have multiple vendors, such as health information fairs, conference expositions, state or community sponsored events, etc.
- A sales event is an event that is sponsored by a plan or another entity with the purpose of marketing to potential members and steering, or attempting to steer, potential members towards a plan.

### Prohibition of Meals

Prospective enrollees may not

- Be provided meals
- Have meals subsidized
- At any event or meeting where
  - Plan benefits are being discussed, or
  - Plan materials are being distributed

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Medicare Advantage Plans and Other Medicare Plans

- Medicare Advantage and Medicare Prescription Drug Plans may not allow prospective enrollees to be provided meals, or have meals subsidized, at sales events or any meeting at which plan benefits are being discussed and/or plan materials are being distributed.
- Agents and/or Brokers are allowed to provide refreshments and light snacks to prospective enrollees. Plans must use their best judgment on the appropriateness of food products provided, and must ensure that items provided could not be reasonably considered a meal, and/or that multiple items are not being "bundled" and provided as if a meal.
- While CMS does not intend to define the term "meal" or create a comprehensive list of food products that qualify as light snacks, items similar to the following could generally be considered acceptable:
  - fruit, raw vegetables, pastries, cookies or other small dessert items, crackers, muffins, cheese, chips, yogurt, and nuts.
- As with all marketing regulation and guidance, it is the responsibility of MA and PDP organizations to monitor the actions of all agents selling their plan(s) and take proactive steps to enforce this prohibition. Oversight activities conducted by CMS will verify that plans and agents are complying with this provision, and enforcement actions will be taken as necessary.

### **State Licensure of Agents**

- MA and PDP organization agents/brokers
  - Must be state-licensed, certified, or registered
    - Applies to contracted and employed agents/brokers

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- MA organizations and Part D sponsors that conduct marketing through independent agents must use state-licensed, certified, or registered individuals.
- Both independent agents and internal sales staff that perform marketing must be licensed.

### **State Appointment of Agents**

- Organizations must comply with state appointment laws
  - Plans must give information about agents
- Required appointment fees must be paid

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- MA and PDP organizations must comply with state appointment laws that require plans to give the state information about which agents are marketing the Part C and Part D plans.
- Organizations must also pay any fees that would be charged in connection with state appointment laws.

### **Reporting of Terminated Agents**

- Organizations must report termination of agents/brokers
  - In accordance with state appointment law
  - To state where agent/broker is appointed
  - Must include reasons for termination

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Medicare Advantage Organizations (MAOs) or Part D sponsors must report the termination of any brokers or agents, and the reasons for the termination, to the state in which the broker or agent has been appointed in accordance with the state appointment law.

### **Agent/Broker Compensation**

- Rules
  - For contracted and employed agents/brokers
  - Designed to eliminate incentives
    - i.e. Encouraging inappropriate moves from plan to plan

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Compensation rules for MA and PDPs that market through agents/brokers, both contracted and employed, are designed to eliminate incentives that encouraged inappropriate moves from plan to plan.

### **Agent/Broker Training and Testing**

- Agents/brokers must be trained/tested annually
  - Medicare rules and regulations
  - Plan details specific to plan products sold
  - Both contracted and employed agents
  - Completed prior to start of marketing season
    - · To market after that date

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Medicare Advantage Plans and Other Medicare Plans

- MAOs and Part D sponsors must ensure that annually brokers and agents selling Medicare products are trained on Medicare rules and regulations, and on plan details specific to the plan products being sold by the brokers and agents.
- MAOs and Part D sponsors must also ensure that brokers and agents selling Medicare products are tested annually on their knowledge of Medicare rules and regulations, as well as, on the plan specific details of the plan products being sold. Training and testing must be completed prior to the start of the new marketing season in order for the broker/agent to market after that date.

### **Agent/Broker Training and Testing**

- Passing score of 85% required
  - Written or computerized
  - Must maintain integrity
  - Must have process for those who don't pass the test

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■ In order to sell Medicare products, a broker or agent should receive a passing score of at least 85% on the test. Tests may be in the form of a written or computerized test. Organizations and sponsors must ensure that their training and testing programs are designed and implemented in a way that the integrity of the training and testing is maintained. In doing so, they must have a process for handling instances in which agents do not pass the test on the first try.

### **CMS Marketing Surveillance**

- Oversight of marketing activity
  - Detect, prevent and respond to marketing violations
  - Secret shopping public sales events
  - Secret shopping one-on-one appointments
  - Special focus on non-renewals (NR)
    - In 55 markets with highest NR rates
    - Plan call centers

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Medicare Advantage Plans and Other Medicare Plans

- Oversight of marketing activity vulnerability in marketing was identified due to persistent complaints and evidence of agent and broker misconduct. CMS developed a comprehensive surveillance strategy designed to detect, prevent, and respond to marketing violations. CMS continues and adds to its surveillance strategy to monitor for marketing compliance, including:
  - Secret shopping to assess compliance with marketing requirements at public sales events.
  - One-on-one (staged) appointment secret shopping to assess compliance with marketing requirements at one-on-one settings with marketing agents and plan representatives.
  - Non-renewal focus secret shopping in markets with highest NR rates to ensure remaining plans were not using scare tactics to gain enrollees.
  - Secret shopping of non-renewing (NR) plan's call centers to assess the accuracy of customer services representative information to potential enrollees related to NR activity.

### **CMS Marketing Surveillance**

- Surveillance strategy
  - Clipping Service (newspaper ads)
  - Website review
  - "Real-time" observations and responses
  - Ensure plans detect, report, and respond to agent/broker marketing misrepresentation

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Medicare Advantage Plans and Other Medicare Plans

- CMS surveillance strategy to monitor for marketing compliance, continued:
  - Clipping Service (newspaper ads) to assess whether marketing events are reported to CMS and to examine marketing ads for inappropriate/misleading language around NR activity
  - Marketing website review to verify that required marketing identification numbers and approval dates are present on each website and that required links are active.
  - Ensuring that health and drug plans detect, report, and respond to agent/broker marketing misrepresentation and other issues.
- The CMS surveillance philosophies include "real-time" observations and responses, resources allocated initially based on risk then adjusted based on performance, providing the industry the opportunity to research and respond to violations, compliance action is taken only when deficiencies are confirmed and validated, and the severity of compliance action is based on severity and recurrence of violations.
- There is still room for improvement. Approximately 40% of public sales events had one or more violations. There has been a lower incidence of egregious behavior/aggressive marketing tactics than prior years, but there are still problems in providing clear, complete, and accurate information around health plan and drug benefits.

## When you can Join or Switch MA Plans\*

New in 2011 Annual Disenrollment Period

Between January 1—February 14

Can leave MA plan

New in

2011

Switch to Original Medicare

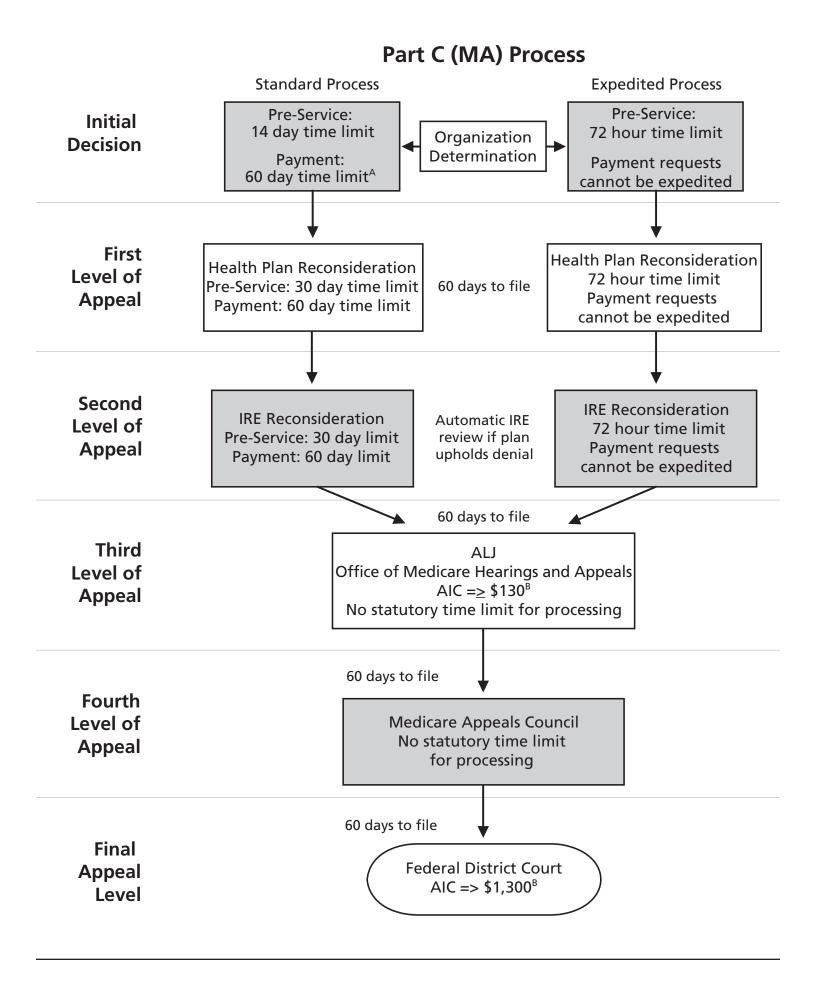
Coverage begins first day of month after switch

May join Part D Plan

Drug coverage begins first day of month after plan gets enrollment

May not join another MA plan during this period

\*Plan must be allowing new members to join



# **NOTES:**

# **NOTES:**



E-mail: NMTP@cms.hhs.gov Website: cms.gov/NationalMedicareTrainingProgram

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